



State of Rhode Island & Providence Plantations
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
One Capitol Hill
Providence, RI 02908-5864
Phone: (401) 222-3160 Fax: (401)222-6391

Summary of Your Employee Medical Benefits

January 1, 2012

Dear Employee:

This letter and attached chart provide a summary of your State of Rhode Island employee medical benefits. Our health plan gives you the freedom to see any physician or other health care professional from the UnitedHealthcare Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that you may be required to pay higher co-payments for care received from a non-network physician, facility or other health care professional. In addition, if you choose to seek care outside the Network, you will also be responsible for payment of the difference between the provider's billed charges and the expenses eligible for reimbursement. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*. You may also call UnitedHealthcare directly at (866) 202-0434 or check online at www.myuhc.com to determine if a physician or facility is in the Network.

Some of the important benefits of our plan include:

- No annual deductible.
- No maximum plan benefit.
- Emergencies are covered anywhere in the world.
- Routine check-ups are covered.
- Prenatal care and childhood immunizations are covered.
- Mammograms and pap smears are covered.

A detailed Summary Plan Description (SPD) is available on-line at www.employeebenefits.ri.gov. Please refer to the SPD for a complete up-to-date listing of services, limitations, exclusions, and a description of all the terms and conditions of coverage. Printed copies are available upon request from your agency HR Staff. If you have questions about whether or not a procedure is a covered benefit, please call UnitedHealthcare at (866) 202-0434.

Sincerely,

Office of Employee Benefits

State of Rhode Island Benefits Summary: 2008 Active Employees, Updated 1/1/12.

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
1. Ambulance Services – Emergency Ground Transportation Air/Water Transportation	0% of Eligible Expenses 0% of Eligible Expenses up to \$3,000	Same as Network Benefit Same as Network Benefit
2. Cardiac Rehabilitation Inpatient – Up to 12 weeks or 36 visits, whichever comes first. Outpatient – 3 visits per week up to 12 weeks.	0% of Eligible Expenses 20% of Eligible Expenses	20% of Eligible Expenses **20% of Eligible Expenses
3. Chiropractic Treatment Maximum 12 visits per year.	\$20 per visit	20% of Eligible Expenses
4. Dental Services– Accident only	0% of Eligible Expenses	*Same as Network Benefit
5. Diabetes Education 1 pre-assessment, 5 individual, and 7 group sessions.	\$20 per visit	20% of Eligible Expenses
6. Durable Medical Equipment / Medical Supplies/Prosthetic Devices Inpatient Outpatient	0% of Eligible Expenses 20% of Eligible Expenses	20% of Eligible Expenses **20% of Eligible Expenses
7. Emergency Health Services Covered anywhere in the world.	\$100 per visit (Waived if admitted to hospital within 24-hours)	Same as Network Benefit
8. Hearing Aids Coverage for a Hearing Aid must be ordered by a Physician and is limited to \$5,000 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every 3 years.	20% of Eligible Expenses	20% of Eligible Expenses
9. Hemodialysis Services Inpatient or in <i>your</i> home, when under the supervision of a hospital or program approved by UHC.	0% of Eligible Expenses	20% of Eligible Expenses
10. Hemophilia Services Up to 56 treatments/calendar year. Subject to office visit co-payment if received in doctor's office.	0% of Eligible Expenses	20% of Eligible Expenses

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
11. Home Health Care/Home Infusion Therapy When part of a coordinated home care program. When not part of a coordinated home care program	0% of Eligible Expenses 20% of Eligible Expenses	*20% of Eligible Expenses *,**20% of Eligible Expenses
12. Hospice Care Approved hospice care providers only.	0% of Eligible Expenses	*20% of Eligible Expenses
13. Hospital – Inpatient Stay Unlimited days at a general hospital; 45 days/calendar year at specialty hospital or in a general hospital for specialty services. Doctor’s Hospital Services – 1 visit per day per specialty Surgery Services - Inpatient	0% of Eligible Expenses 0% of Eligible Expenses	*20% of Eligible Expenses 20% of Eligible Expenses **20% of Eligible Expenses
14. House Calls	\$10 per visit for PCP \$20 per visit for Specialist	20% of Eligible Expenses
15. Human Leukocyte Antigen Testing Once per member per lifetime	0% of Eligible Expenses	20% of Eligible Expenses
16. Infertility Services Includes infertility drugs not obtained at pharmacy	20% of Eligible Expenses	**20% of Eligible Expenses
17. Injections Received in a Physician’s Office	0% of Eligible Expenses	20% per injection
18. Maternity Services Pre-natal, post-natal, and delivery. Notification is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a caesarian section delivery.	0% of Eligible Expenses No Copayment applies to Physician office visits for prenatal care after the first visit in which a \$20 copayment applies	*20% of Eligible Expenses
19. Mental Health and Substance Abuse Services – Outpatient Inpatient and Intermediate Mental Health Substance Abuse Rehabilitation Substance Abuse Detoxification	\$10 per individual or group visit 0% of Eligible Expenses	20% of Eligible Expenses *20% of Eligible Expenses

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
20. Nutritional Counseling 6 visits per calendar year when prescribed by a physician for treatment of specific health conditions.	0% of Eligible Expenses	20% of Eligible Expenses
21. Outpatient Services Outpatient Surgery Outpatient Diagnostic/Therapeutic Services – Laboratory Tests, CT Scans, Pet Scans, and MRI	0% of Eligible Expenses 0% of Eligible Expenses	20% of Eligible Expenses 20% of Eligible Expenses
22. Physical/Occupational Therapy Inpatient Outpatient – Therapy beginning within 30 days following a hospital stay, home care program, or ambulatory surgical procedure. Outpatient – Not Following a Hospital Stay Outpatient – In a Doctor's or Therapist's Office	0% of Eligible Expenses 0% of Eligible Expenses 20% of Eligible Expenses 20% of Eligible Expenses	20% of Eligible Expenses 20% of Eligible Expenses **20% of Eligible Expenses **20% of Eligible Expenses
23. Physician's Office Services Primary Care Physician Internal Medicine, Family Practice, Pediatrics and Geriatrics Specialist Physician Office Visits All physicians other than Primary Care Physicians (see above) Routine Annual Physicals and Annual Gynecological visits Pediatric Preventive Birth - 12 months: 7 visits 13 - 35 months: 3 visits 36 months - 19 years: 1 per calendar year	\$10 per visit. \$20 per visit. No copay applies when a Physician charge is not assessed 0% of Eligible Expenses 0% of Eligible Expenses	20% of Eligible Expenses 20% of Eligible Expenses 20% of Eligible Expenses 20% of Eligible Expenses
24. Private Duty Nursing If no intensive care unit available	0% of Eligible Expenses	*0% of Eligible Expenses
25. Radiation/Chemotherapy Services Radiation Therapy/Chemotherapy – Inpatient/Outpatient Chemotherapy Services in a doctor's office. Includes drugs and administration	0% of Eligible Expenses 20% of Eligible Expenses	20% of Eligible Expenses **20% of Eligible Expenses
26. Respiratory Therapy	0% of Eligible Expenses	20% of Eligible Expenses

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
27. Scalp Hair Prosthesis Network and Non-Network Benefits for a scalp hair prosthesis are limited to \$350 per calendar year.	20% of Eligible Expenses See maximum plan benefit at left.	20% of Eligible Expenses See maximum plan benefit at left.
28. Skilled Care in a Nursing Facility	0% of Eligible Expenses	*20% of Eligible Expenses
29. Speech Therapy Outpatient In a doctor's/therapist's office	20% of Eligible Expenses	*, **20% of Eligible Expenses
30. Transplantation Services Must be performed at a Center of Excellence	0% of Eligible Expenses	Not available
31. Tobacco Cessation Treatment – Outpatient Visits Network and Non-Network Benefits are limited to eight, thirty (30) minute counseling sessions each calendar year.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Summary Plan Document.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Summary Plan Document.
32. Urgent Care Center Services	\$35 per visit	20% of Eligible Expenses
Prescription Coverage Injectable Drugs obtained at the pharmacy Injectable drugs provided by a doctor and administered in a doctor's office	Same as pharmacy coverage 0% of Eligible Expenses	Same as pharmacy coverage 0% of Eligible Expenses
Pharmacy Coverage Quantity Limit per co-payment: Up to a 31-day supply	\$5 Tier 1 \$20 Tier 2 \$40 Tier 3	**\$5 Tier 1 **\$20 Tier 2 **\$40 Tier 3
Mail Order network pharmacies: ▪ For up to a 90 day supply	\$10 Tier 1 \$40 Tier 2 \$80 Tier 3	Not covered

*Pre-authorization is recommended for this service. If you do not obtain pre-authorization and the services are determined to be not medically necessary or the setting where services were received is determined to be inappropriate, this plan will not cover these services.

**Out-of-pocket amounts on this benefit will not accumulate to the annual maximum out-of-pocket expense. This benefit level will not increase due to having satisfied the annual maximum out-of-pocket expense through other benefits.

Covered Health Service

**Within the UHC
Network you pay:**

**Outside of the UHC
Network you pay:**

Network Out-of-Pocket Maximum: No Out-of-Pocket maximum

Non-Network Out-of-Pocket Maximum: \$3,000 per Covered Person per calendar year, not to exceed \$9,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD.

Non-Network Charges: If you choose to seek care outside the Network, you will also be responsible for payment of the difference between the provider's billed charges and the expenses eligible for reimbursement.

Dependent Age: Children are eligible for coverage until the end of the month that the child turns age 26, provided the child does not have access to employer-sponsored medical insurance through his/her employer.

This Summary of Benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. More complete descriptions of Benefits and the terms under which they are provided, including related exclusions, are contained in the Summary Plan Description available online at www.employeebenefits.ri.gov. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefits Summary are defined in the Summary Plan Description.